Deposition Designations for:
JOHN PARKER
June 9, 2009

Deposition Designation Key

Arrowood = Arrowood Indem. Co. f/k/a Royal Indem. Co. (Light Green)

BNSF = BNSF Railway Co. (Pink)

Certain Plan Objectors "CPO" = Government Employees Insurance Co.; Republic Insurance Co. n/k/a Starr Indemnity and Liability Co.; OneBeacon America Insurance Co.; Seaton Insurance Co.; Fireman's Fund Insurance Co.; Allianz S.p.A. f/k/a Riunione Adriatica Di Sicurta; and Allianz SE f/k/a Allianz Aktiengesellschaft; Maryland Casualty Co.; Zurich Insurance Co.; and Zurich International (Bermuda) Ltd.; Continental Casualty Co. and Continental Insurance Co. and related subsidiaries and affiliates; Federal Insurance Co.; and AXA Belgium as successor to Royal Belge SA (Orange)

CNA = Continental Cas. Co & Continental Ins. Co. (Red)

FFIC = Fireman Funds Ins. Co. (Green)
FFIC SC = Fireman Funds Ins. Co. "Surety Claims" (Green)

GR = Government Employees Ins. Co.; Republic Ins. Co. n/k/a Starr Indemnity and Liability Co.

Libby = Libby Claimants (Black)

OBS = OneBeacon America Ins. Co. and Seaton Ins. Co. (Brown)

PP = Plan Proponents (Blue)

Montana = State of Montana (Magenta)

Travelers = Travelers Cas. and Surety Cos. (Purple)

UCC & BLG = Unsecured Creditors' Committee & Bank Lenders Group (Lavender)

AFNE = Assume Fact Not in Evidence
AO = Attorney Objection
BE = Best Evidence
Cum. = Cumulative
Ctr = Counter Designation
Ctr-Ctr = Counter-Counter
ET = Expert Testimony
F = Foundation
408 = Violation of FRE 408
H = Hearsay
IH - Incomplete Hypothetical
L = Leading
LA = Legal Argument
LC = Legal Conclusion
LPK - Lacks Personal Knowledge
LO = Seeking Legal Opinion
NT = Not Testimony
Obj: = Objection
R = Relevance
S = Speculative
UP = Unfairly Prejudicial under Rule 403
V = Vague

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

In re:	Chapter 11
W.R. GRACE & CO., et al.,	Case No. 01-01139 (JKF)
Debtors.	Jointly Administered
	Ref. No. 21544

DEPOSITION OF JOHN PARKER, M.D.,

a witness herein, called for examination by the Claimants, taken pursuant to the Federal Rules of Bankruptcy Procedure, by and before Susan E. Alldridge, a Registered Professional Reporter and Notary Public in and for the State of West Virginia, at the Ramada Inn Conference Center, 20 Scott Avenue, Morgantown, West Virginia on Tuesday, 9 June 2009, at 9:09 a.m.

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winchite-asbestos and what kind of asbestos disease it causes?
A. There's a tremendous body of epidemiologic evidence about the human health effects of the Libby amphibole contained in work by Harlan Amandus and Corbett McDonald and a follow-up by a Dr. Sullivan. So there's a great deal of substantiation of the human health effects, perhaps more than many other cohorts in the world that have been studied.
Q. In this phrase "and progresses very rapidly," what did you mean by that?
A. Again, in Dr. Whitehouse's March 2009 deposition, he seems very concerned that people's lung function testing may change very dramatically over a short period of time.
Q. Okay. So in this sentence that we've focused on, beginning in the third line of page 10, did you mean to say "and may progress very rapidly"?
A. That would be okay.
Q. As you've written it, do you see that it would be understood as generally progresses very rapidly or just progresses very rapidly, period?

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A. I believe the antecedent sentence that it's referring to is a statement that "Asbestos disease due to Libby asbestos exposure is first diagnosable. Usually there are no symptoms, only positive findings on a chest x-ray or CT. The disease may take decades to progress to a point of severity." And that is a very typical textbook description of asbestos-related disease.
But he's expressed views in his 2009 deposition that it progresses very rapidly, although I would certainly allow the qualifier "may progress very rapidly."
Q. Is it your understanding from the March 2009 Whitehouse deposition that he's saying it progresses very rapidly in all cases?
A. No.
Q. So "may progress very rapidly" would be more correct?
A. That would be fine.
Q. And then the next sentence, you say, "Libby cohorts have asbestos-related disease quite typical of amphibole-exposed cohorts."
Do you see that?
A. Yes.

PP Ctr.

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Q. What did you mean by "Libby cohorts," pleural?
A. The occupationally exposed cohorts that have been studied by Amandus and McDonald and Sullivan and the community cohorts that have been studied by the American -- the Agency for Toxic Substances and Disease Registry have asbestos disease that's quite typical of amphibole-exposed cohorts.
Q. In what way?
A. They have more pleural disease than parenchymal disease, and they have pleural disease that is frequently calcified. Those are the main ways in which those cohorts are similar.
Q. Is it also typical in the sense that there's predominantly visceral pleural thickening with significant extent and thickness to it?
A. The presence of pleural disease in excess of the parenchymal disease is different with amphiboles than most Chrysotile-exposed populations, and that seems to be the case in Libby.
Q. And did you see a predominance in the pleural thickening -- of visceral pleural

PP Ctr.

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thickening over pleural plaques?
A. No. Pleural plaques far exceed the presence of diffuse pleural thickening in x-rays that I've seen from Libby, including an enriched film set that I saw in February and April of this year.
Q. What does "enriched" mean?
A. There were a set of films selected by Brad Black, to show extensive pleural disease, that were given to the ATSDR, for those people to have CT scans within the last two years and then have a comparison of digitally acquired chest x-rays and analog-acquired traditional chest x-rays to be compared by six readers in the ATSDR study and then compared also with the CT scans.
Q. How many --
A. And that cohort had much more parietal pleural plaques than diffuse pleural thickening.
Q. How many --
A. And the same was true of the nearly 7,000 films I looked at from the Libby community and occupational study reported by Peipins.
Q. How many films were in the enriched series?

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A. 200. And we looked at those films as an analog study, as a digital study, and as a CT study. And we looked at them twice in each format.
Q. Does "analog" mean hard copy?
A. Analog means film screen acquired, a traditional x-ray, as opposed to a digitally acquired x-ray, which is a different technology. The digital we looked at on a computer screen, and the analog were looked at as a hard copy.
Q. On a light box?
A. On a light box, a view box, yes.
Q. Okay. Is there a paper written on this project?
A. Not yet, no.
Q. There isn't even a draft, I take it?
A. I don't believe so.
Q. So in the predominance of pleural disease over interstitial fibrosis, you say that's typical of amphibole-exposed cohorts?
A. Yes.
Q. What amphibole-exposed cohorts have you looked at?
A. Cohorts from South Africa, cohorts from Australia, cohorts from the Eastern seaboard of the

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United States, cohorts from Finland, and cohorts from Libby, Montana. There may be more, but that's what I recall at this time.
Q. And the Australian cohort, was that from the area of the Wittenoom mine?
A. Some of the papers have come from the Wittenoom mine, and the experiences reported by Australians, yes.
Q. You mentioned papers. Have you actually looked at films from that area as well?
A. Yes.
Q. Was that as part of a project?
A. Yes.
Q. What project?
A. It was a project that James Lee had put together.
Q. Is there a paper published as a result of that?
A. No.
Q. And then what was the South African cohort?
A. Yes. Those were people that Dr. Neil White included in a series of x-rays that we were applying the ILO classification system to.

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Q. Is there a paper from that one?
A. No. There's a paper on tuberculosis from that but not on the amphiboles.
Q. You mentioned from the East Coast. Was that an amosite cohort?
A. Primarily, yes.
Q. Is that the Paterson, New Jersey, plant?
A. Those were films that Dr. Irving Selikoff produced for me and others to look at. Dr. Ruth Lilis produced for my review. And Dr. Al Miller produced for my review.
Q. And these were predominantly amosite --
A. Yes.
Q. -- exposures?
A. Yes.
Q. Did a paper get written out of that one?
A. Well, they've written many papers about it, but I did not participate in a reading trial that generated papers. It was a training exercise.
Q. And the Finland was what kind of asbestos?
A. That's mostly anthophyllite. And Anders Zitting was the person I collaborated with primarily on that, and Matti Huuskonen. And they have many papers on it, but there was no paper

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produced from the radiographs I reviewed with them.
Q. And the predominantly pleural disease over interstitial fibrosis, that would be different from Chrysotile in a significant way?
A. Chrysotile does not produce as much pleural abnormality as parenchymal abnormality, in my experience.
Q. Is it significantly less?
A. It's related to dose response relationships affecting the pleura and the parenchyma.
Q. I was wondering if it's significantly less than amphibole --
A. Yes.
Q. -- cohort.
A. Yes.
Q. Okay. And in your review of Libby chest x-rays, did you see a lot of thin but extensive visceral pleural thickening?
A. Most costophrenic angle blunting that was present was also accompanied by parietal pleural plaques. There also was some costophrenic angle blunting that would meet the definition of B2 by ILO. I suspect most of what I saw of costophrenic

Libby

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angle blunting would meet the B2 ILO definition, at least unilaterally.
Q. I was asking about thin but extensive --
A. I did not --
Q. -- visceral pleural thickening. Did you see a lot of that?
A. I saw some costophrenic angle blunting that would not meet the ILO definition of B2 but would meet the ILO definition of B1.
Q. And would that be significantly different than Chrysotile presentations?
A. Yes, in my experience.
Q. And in the Libby x-rays, did you see a lower incidence of blunting with visceral pleural thickening than you've seen elsewhere?
A. No.
Q. And in the Libby chest x-rays, did you see significant subpleural interstitial fibrosis?
A. It's been present but not different than other cohorts.
Q. Not different than other amphibole cohorts?
A. Yes.
Q. Would that be different from Chrysotile

Libby

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cohorts?
A. Not always.
Q. "Not always," did you say?
A. Yes.
Q. Generally, is it?
A. Generally, yes.
Q. And in the Libby chest x-rays, did you see more -- or did you see cases of pure pleural disease with no interstitial fibrosis?
A. Yes.
Q. And is that consistent with other amphibole cohorts?
A. Yes.
Q. And is that also significantly different from Chrysotile cohorts?
A. Not always, no.
Q. Generally so?
A. Yes.
Q. And when you compared CT scans to chest x-rays on the same people from Libby, did you note that the CT scans showed a lot more pleural disease?
A. Yes. The CT scans did demonstrate more pleural disease than was appreciated on the chest

PP Obj: R

Libby

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x-ray.
Q. And is that consistent with amphibole cohorts?
A. Yes. And Chrysotile cohorts.
Q. And then you mentioned the amosite cohort from Paterson, New Jersey. Did you do any work on that same cohort after it moved to Tyler, Texas?
A. No, I did not.
Q. A lot of the same workers moved from New Jersey to Texas, didn't they?
A. I'm not sure if it was the workers who moved. I guess it was the workers who moved. I was going to say also some of the investigators moved, too.
Q. Any other amphibole cohorts in the United States that you've done work on?
A. No, I don't believe so.
Q. On page 10 of Exhibit 1, just above the new caption "The Importance Of," there's a sentence beginning "The Libby radiographic and clinical findings are consistent with international populations exposed to amphibole asbestos."
And what are you referring to in terms of clinical findings there?

PP Obj: R

Libby

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A. Could you redirect me? I actually didn't see where it was.
Above the bold.
Q. Yes.
A. Yes. I meant that populations exposed to amphiboles in Finland and Turkey and Australia and South Africa and other locations have had radiographic findings with extensive pleural abnormalities sometimes reported. And clinical findings of effusions, clinical findings of rounded atelectasis, clinical findings of parietal plaques, clinical findings of lung cancer, clinical findings of diffuse pleural thickening have been identified in other international populations that are amphibole exposed. And the Libby's findings were quite typical of those that have been seen and reported internationally.
Q. Okay. So as to effusions, the Libby findings are consistent with amphiboles?
A. Yes.
Q. And would you say the incidence of effusions in Libby is significantly greater than in Chrysotile cohorts?
A. Yes. I haven't seen a lot of films myself

PP Obj: R

Libby

PP Obj: R

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with effusions from Libby, but the experience reported would make me think that it's more than with Chrysotile, yes.

Q. And as to rounded atelectasis, were the Libby films consistent with other amphibole cohort films?

A. Yes.

Q. And significantly greater than Chrysotile cohorts?

A. Yes.

Q. And as to the incidence of diffuse pleural thickening, was Libby consistent with amphibole cohorts on that issue?

PP Obj: R; F

A. Yes.

Q. And significantly greater than Chrysotile cohorts?

A. Possibly.

Q. Did you say "possibly"?

A. Possibly.

Q. You're not sure?

A. I'm not certain.

Q. And what about the finding of chest pain? Was -- were the Libby clinical findings in that regard consistent with amphibole cohorts elsewhere?

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A. I don't know -- I don't have any good information on the symptoms of chest pain in the Libby cohort.

Q. And how about the incidence of obstructive disease? Was that consistent in Libby as with amphibole cohorts of elsewhere?

A. I don't have any good information on that. National Jewish did the lung function testing in the largest of the Libby studies and reported in abstract form only and found very little restrictive or obstructive disease, either one.

Q. What set of chest x-rays were they looking at?

A. The Bibi Gottschall and others from National Jewish in Denver. They were looking at spirometry on the 6- or 7,000 people surveyed by ATSDR.

Q. And this is the survey of 6- or 7,000 people reported in Peipins?

A. Yes. That lung function data is not reported in the Peipins paper.

Q. So you've seen some abstract?

A. Yes. I've seen abstract from the National Jewish information on the Libby cohort and maybe

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even a preliminary ATSDR report that showed not very much restrictive and not very much obstructive disease in the cohort. But I don't believe that's in the peer review literature.

Q. Are these documents public?

A. If Bibi Gottschall's was an abstract at ATS, American Thoracic Society, meaning it would certainly be public.

MR. STANSBURY: Jon, just so you know, in the final report to the community, it's in there. The ATSDR's final report for the community, that's where that reference to the PFT results was. That's public.

BY MR. HEBERLING:

Q. And in the other amphibole cohorts, have you found the phenomenon of isolated DLCO?

MR. STANSBURY: Object to form.

THE DEPONENT: And, of course, you're referring to a reduction in DLCO out of proportion to the reduction in FVC?

BY MR. HEBERLING:

Q. I'm referring to DLCO as being the only number that is significantly reduced.

A. The only number that's below 80 percent

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predicted?

Q. Yes. The only number out of DLCO, FVC, TLC.

A. That's not been drawn to my attention. It certainly may have occurred, but I have not seen it.

Q. And page 11 of your report, Exhibit 1, about the fifth line down, it says, "The distinction between asbestosis and pleural plaques is important for prognostic implications to patients including patient education and attendant future health risks. When Dr. Whitehouse blends these two disorders, rather than recognizing them as distinct in prognosis and for patient health education, he does his patients a major disservice."

Do you see that?

A. Yes.

Q. Now, asbestosis can be a severe disease; correct?

A. Yes.

Q. And diffuse pleural thickening can be a severe disease; correct?

A. Yes. My statement is about pleural